NORTHEAST CLINICAL SPECIALISTS, LLC

NAME: _____ ADDRESS: _____
Street

S.S.#: _ _ _ - _ _ - _ _ _ _ **Gender: M F** _____
City, State, Zip

HOME telephone: _____ EMPLOYER: _____

WORK telephone: _____ DATE OF BIRTH: _____

Marital Status Student?

CELL telephone: _____ Marr ___ Single ___ Div ___ Full-time ___Part-time___No___

PRIMARY INSURANCE: Company_____ID# _____
Name of Insured _____ Group # _____
Relationship to client: _____Self _____Spouse _____Parent/Child

SECONDARY INSURANCE: Company_____ID# _____
Name of Insured _____ Group # _____
Relationship to client: _____Self _____Spouse _____Parent/Child

Name and telephone number to contact in an emergency: _____

Primary Care Doctor: _____ Dr's Office Town:_____

How did you learn about us? _____

FEES, PAYMENT AND INSURANCE COVERAGE

As the client, you are responsible for all service charges. Payment is expected at the time of your visit, unless previous arrangements have been made with your therapist. If you are covered by insurance, you may only have to pay the portion of your bill that is not covered by your insurance carrier at the time of your visit, but you are still responsible for the full expense of each visit. Some insurers send payments directly to the insured. If you have not paid the full amount charged for your visits, it is your responsibility to bring or send in all insurance reimbursements which you receive, within five working days. Delinquent accounts may be charged 15% annual interest, compounded monthly and non-payment of bills may result in legal action and/or the use of professional collection services.

By signing below, I am acknowledging that I have read the preceding paragraph and agree to its provisions. I also attest that if the treatment is for a minor, I am requesting treatment for this minor and that I am a parent or guardian legally authorized to give permission for such treatment to occur.

Client/Parent/Guardian Signature _____ Date _____

IF YOU HAVE INSURANCE COVERAGE, please sign below:

CLIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of medical benefits directly to the provider.

SIGNED _____ Date _____

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NCS 09/13 For office use only

Mans Plain Dx _____ Txist _____Co-pay/Fee_____